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Community Support – Adults (MH/SA)
Medicaid Billable Service

Service Definition and Required Components
Community Support consists of mental health and substance abuse rehabilitation services and supports necessary to assist the person in achieving and maintaining rehabilitative, sobriety, and recovery goals. The service is designed to meet the mental health/substance abuse treatment, financial, social, and other treatment support needs of the recipient. The service is also designed to assist the recipient in acquiring mental health/substance abuse recovery skills necessary to successfully address his/her educational, vocational, and housing needs. The Community Support Professional provides coordination of movement across levels of care, directly to the person and their family and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels of care. The service includes providing "first responder" crisis response on a 24/7/365 basis to consumers experiencing a crisis. The service activities of Community Support consist of a variety of interventions: identification and intervention to address barriers that impede the development of skills necessary for independent functioning in the community; family psychoeducation development and revision of the recipient's Person Centered Plan; and one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to home, school, and work environments; therapeutic mentoring; symptom monitoring; monitoring medications; and self management of symptoms. Community Support includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Community Support workers also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services.

The Community Support worker must consult with identified providers, include their input into the Person Centered Planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. The organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient. The Community Support Professional provides coordination of movement across levels of care, directly to the person and their family and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels.

A service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements
Community Support services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH) and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

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The Community Support provider organization is identified in the Person Centered Plan and is responsible for obtaining authorization from the LME for the Person Centered Plan. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, jails*****, homeless shelters, street locations, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Organizations that provide Community Support services must provide "first responder" crisis response on a 24/7/365 basis to recipients who are receiving community support services.

Staffing Requirements
Persons who meet the requirements specified for Qualified Professional or Associated Professionals (AP) status according to 10A NCAC 27G.0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Community Support. Qualified Professionals (QP) are responsible for developing and coordinating the Person Centered Plan. APs and Paraprofessionals may deliver Community Support services to assist the consumer to develop critical daily living and coping skills.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a QP. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

Associate Professionals and Paraprofessional level-providers who meet the requirements specified for Paraprofessional or AP status according to 10A NCAC 27G.0104 may deliver Community Support as follows: service coordination activities within the established Person-Centered Plan, referral linkage, skill building, supportive counseling, and input into the Person-Centered Plan modifications. When a Paraprofessional provides Community Support services, a QP is responsible for overseeing the development of the recipient's Person-Centered Plan.

A Certified Clinical Supervisor (CCS) and Certified Clinical Addiction Specialist (CCAS) may also deliver Community Support.

The following chart sets forth the activities that can be performed by a QP, CCS, CCAS, AP, or Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

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Qualified Professional **Certified Clinical Supervisor** **Certified Clinical Addiction Specialist**	**Associate Professional** **Paraprofessional**
• Coordination and Oversight of Initial and Ongoing Assessment Activities • Initial Development and Ongoing Revision of PCP • Monitoring of Implementation of PCP • Additional Case Management functions of linking, arranging for services and referrals	• Various Skill Building Activities • Training of the caregiver • Daily and Community Living Skills • Socialization Skills • Adaptation Skills • Development of Leisure Time Interests/Activities • Symptom Monitoring and Management Skills • Therapeutic mentoring • Education substance abuse • Behavior and anger management

All staff providing community support to adults must complete a minimum of twenty (20) hours of training specific to the required components of the community support service definition including crisis response within the first 90 days of employment.

Service Type/Setting
Community Support is a direct and indirect periodic service where the Community Support worker provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location*. Community Support services may be provided to an individual or a group of individuals.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Community Support services are provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. Community Support services can also be billed for individuals living in independent living or supervised living (low or moderate). Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. Community Support activities include person-centered planning meetings and meetings for Person Centered Plan development.

Program Requirements
Caseload size for a Community Support qualified professional may not exceed 1:30 QP per thirty [30] clients). Community Support services may be provided to groups of individuals. When Community Support services are provided in a group, groups may not exceed eight (8) individuals.

Units are billed in fifteen (15) minute increments.

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Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- all individuals receiving Community Support must receive a minimum of two (2) contacts per month with one (1) contact occurring face-to-face with the recipient;
- a minimum of sixty percent (60%) or more of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of the recipients.

Entrance Criteria

The recipient is eligible for this service when:

A. there are two (2) identified needs in the appropriate documented life domains

AND

B. there is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability

AND/OR

C. ASAM (American Society for Addiction Medicine) criteria are met

AND

D. the recipient is experiencing difficulties in at least one of the following areas:

1. is at risk for institutionalization, or hospitalization or is placed outside the natural living environment.
2. is receiving or needs crisis intervention services
3. has unmet identified needs for services from multiple agencies
4. needs advocacy and service coordination to direct service provision from multiple agencies
5. DSS has substantiated abuse, neglect, or has established dependency as defined by DSS criteria
6. recipient exhibits intense, verbal and limited physical aggression due to symptoms associated with diagnosis that is sufficient to create functional problems in the home, community, school, job, etc.
7. functional problems that may result in the recipient's inability to access clinic-based services in a timely or helpful manner
8. is in active recovery from substance abuse/dependency and is in need of continuing relapse prevention support

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial Person Centered Plan goals but additional goals are indicated.

B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

~~**AND**~~

~~Utilization review must be conducted a minimum of ninety (90) days (after the initial thirty [30] day authorization review) and is in the recipient's chart.~~

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits from this service, or has the ability to function at this level of care and any of the following apply:

A. Recipient has achieved positive life outcomes that support stable and ongoing recovery.

B. Recipient is not making progress or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.

C. Recipient/family no longer wishes to receive Community Support services.

D. Recipient has achieved one (1) year of abstinence from misuse of substances.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes interventions that address the functional problems associated with complex and/or complicated conditions of the identified population. These interventions are strength-based and focused on promoting recovery, symptom reduction, increased coping skills, and achievement of the highest level of functioning in the community. The focus of the interventions include: minimizing the negative effects of psychiatric symptoms or substance dependence that interfere with the recipient's daily living, financial management and personal development; developing strategies and supportive interventions for avoiding out-of-home placements for adults; supporting ongoing treatment; assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's disability and coordinating rehabilitation services in the Person Centered Plan.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, the signature and credentials of the staff providing the service.

Entrance Process
Medicaid covers up to eight unmanaged Qualified Professional hours for the purpose of collecting information to develop and initiate the Person Centered Plan (PCP). Relevant diagnostic information must be obtained to complete the PCP. This requirement may be fulfilled through the Diagnostic/Assessment, intake or recent diagnostic information. No additional Community Support services can be requested without a complete PCP with signatures and an ITR.

The Qualified Professional may link the recipient to an alternate service within the 8-hour timeframe. This must be documented in the PCP and ITR submitted to the statewide vendor.

Utilization Management
Authorization by the statewide vendor is required after eight unmanaged Qualified Professional hours. The statewide vendor will evaluate the request to determine if medical necessity supports more or less intensive services. ~~The amount, duration, and frequency of services must be included in an individual's Person-Centered Plan and authorized on or before the day services are to be provided. Initial authorization for services must not exceed 30 days. Reauthorization will occur a minimum of ninety (90) days thereafter by the statewide vendor and is to be documented in the Person-Centered Plan and service record.~~

If it is a Medicaid covered service, utilization management will be conducted by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

~~A maximum of thirty-two (32) units of Community Support services can be provided in a 24-hour period. No more than 112 units per week of services can be provided to an individual unless additional service is authorized based on medical necessity.~~

Medicaid covers up to 780 units for a 90-day period based the medical necessity documented in the PCP and supporting documentation. If the initial benefit of 780 units is expended before the end of the 90-day period, an updated PCP and a new ITR must be submitted to the statewide vendor to request alternate services. Additional units may be authorized on a time-limited basis to allow time for the Qualified Professional to coordinate these alternate services.

If continued Community Support services are needed at the end of the 90-day authorization period, an updated PCP and a new ITR reflecting the appropriate level of care and service must be submitted to the statewide vendor. This should occur no later than 30 days prior to the expiration of the initial authorization.

Note: Community Support services are not intended to be a long-term service. Continued requests beyond the first six months require significant justification.

Service Exclusions/Limitations
An individual can receive Community Support services from only one Community Support provider organization at a time.

Medicaid covers Community Support services for ~~can be provided to~~ individuals residing in ~~all~~ adult mental health residential facilities ~~levels~~ (i.e., Supervised Living Low or Moderate and Group Living Low, Moderate or High).

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Group Community Support services cannot be billed on the same day as Psychosocial Rehabilitation services.

~~Community Support cannot be provided during the same authorization period with the following services except as specified below: Partial Hospitalization, SACOT, SAIOP or SA Non-Medical Community Residential Treatment.~~

~~**Service Limitations:** Community Support services can be billed for a maximum of eight (8) units per month in accordance with the PCP for individuals, who are receiving a service listed above, to facilitate admission/transition to the service, to provide coordination during the provision of the service and /or to transition from the service based on the Person Centered Plan.~~

For the purpose of facilitating an admission to a service; a transition to or from a service; or to provide coordination during the provision of a service, Medicaid covers up to 8 units of Community Support Services per calendar month for individuals who are authorized to receive one of the following services during the same authorization period:

- Assertive Community Team Treatment
- Non-hospital Medical Detoxification
- Partial Hospitalization
- Psychosocial Rehabilitation
- Substance Abuse Comprehensive Outpatient Treatment
- Substance Abuse Intensive Outpatient Treatment
- Substance Abuse Medically Monitored Community Residential Treatment

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

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Community Support – Children/Adolescents (MH/SA)
Medicaid Billable Service

Service Definition and Required Components
Community Support services are services and supports necessary to assist the youth ages 3 to 17 years of age or younger (20 years old or younger for children enrolled in Medicaid) and their caregivers in achieving, rehabilitative, and recovery goals. Community Support services are psychoeducational and supportive in nature and intended to meet the mental health or substance abuse needs of children and adolescents with significant functional deficits or who, because of negative environmental, medical or biological factors, are at risk of developing or increasing the magnitude of such functional deficits. Included among this latter group are those at risk for atypical development, substance abuse, or serious emotional disturbance (SED) that could result in an inability to live successfully in the community without services and guidance.

The service activities of Community Support consist of a variety of interventions: education and training of caregivers and others who have a legitimate role in addressing the needs identified in the Person Centered Plan; preventive, and therapeutic interventions designed for direct individual activities; assist with skill enhancement or acquisition, and support ongoing treatment and functional gains; development of the consumer's Person Center Plan, and one-on-one interventions with the consumer to develop interpersonal and community relational skills, including adaptation to home, school, work and other natural environments; therapeutic mentoring; and symptom monitoring and self-management of symptoms. Community Support includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Community Support workers also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services. The Community Support Professional provides coordination of movement across levels of care, directly to the person and their family and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels of care. The service includes providing "first responder" crisis response on a 24/7/365 basis to consumers experiencing a crisis.

A service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements
Community Support services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

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Community Support providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions.

Organizations that provide Community Support services must also provide 24/7/365 crisis response to consumers and their families who are receiving community support services.

Staffing Requirements
Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Community Support within the requirements of the staff definition specified in the above rule. Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline.

Associate Professionals and Paraprofessional level providers who meet the requirements specified for Paraprofessional or AP status according to 10A NCAC 27G.0204 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Community Support services as follows: service coordination activities within the established Person-Centered Plan, referral linkage, skill building, supportive counseling, and input into the Person-Centered Plan modifications. When an AP or Paraprofessional provides Community Support services, these services must be under the supervision of a QP. Supervision of APs or Paraprofessionals is also to be carried out according to 10A NCAC 27G.0204.

The following chart sets forth the activities that can be performed by a QP, CCS, CCAS, AP, and Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Qualified Professional **Certified Clinical Supervisor** **Certified Clinical Addiction Specialist**	**Associate Professional** **Paraprofessional**
• Coordination and Oversight of Initial and Ongoing Assessment Activities • Initial Development and Ongoing Revision of PCP • Monitoring of Implementation of PCP • Other case management functions of linking and referring	Various Skill Building Activities • Training of caregiver • Daily and Community Living Skills • Socialization Skills • Adaptation Skills • Symptom Monitoring and Management Skills • Education substance abuse • Therapeutic mentoring • Behavior and anger management techniques

All staff must complete a minimum of twenty (20) hours of training specific to the required components of the community support service definition including crisis response within the first 90 days of employment.

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Service Type/Setting
Community Support is a direct and indirect periodic service where the Community Support worker provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location*. Community Support services may be provided to an individual or a group of individuals.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. Community Support activities include person-centered planning meetings and meetings for Person Centered Plan development.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions (detention centers/ youth correctional facilities, jails).

Program Requirements
Caseload size for a Community Support qualified professional may not exceed 1 to 15 Community Support services may be provided to groups of individuals. When Community Support services are provided in a group, groups may not exceed eight individuals.

Units are billed in fifteen (15) minute increments.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. Annually the aggregate services that have been delivered by the agency will be assessed for each provider agency using the following quality assurance benchmarks:

- all youth receiving Community Support must receive a minimum of two (2) contacts per month with one (1) contact occurring face-to-face with the recipient;
- a minimum of sixty percent (60%) or more of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers.

Entrance Criteria
The recipient is eligible for this service when:

A. there are two (2) identified needs in the appropriate documented life domains

AND

B. there is an Axis I or II diagnosis present, other than a diagnosis of primary Developmental Disability

AND/OR

C. NC Modified ASAM (American Society for Addiction Medicine),

AND

D. the recipient is experiencing difficulties in at least one of the following areas:
    1. is at risk for institutionalization or hospitalization or is placed outside the natural living environment
    2. is receiving or needs crisis intervention services or Intensive In-Home services
    3. has unmet identified needs from multiple agencies

4. needs advocacy and service coordination to direct service provisions from multiple agencies
5. DSS has substantiated abuse, neglect, or has established dependency
6. presenting with intense, verbal, and limited physical aggression due to symptoms associated with diagnosis, which aggression is sufficient to create functional problems in the home, community, school, job, etc.
7. functional problems which may result in the recipient's inability to access clinic-based services in a timely or helpful manner
8. is in active recovery from substance abuse/dependency and is in need of continuing relapse prevention support

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains; or any one of the following apply:

A. Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the Person Centered Plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

~~**AND**~~
~~Utilization review must be conducted a minimum of every ninety (90) days (after the initial thirty [30] day authorization) and is so documented in the Person-Centered Plan and service record.~~

Discharge Criteria
Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down; or no longer benefits from this service, or has the ability to function at this level of care; and any of the following apply:

A. Recipient has achieved goals and is no longer eligible for Community Support services.
B. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
C. Recipient/family no longer wants Community Support services.
D. Recipient has achieved one (1) year of abstinence from substances.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

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Expected Outcomes
This service includes interventions that address the functional problems associated with complex and/or complicated conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increased coping skills, and achievement of the highest level of functioning in the community. For substance abusers, the expected outcomes include the achievement of abstinence from substances. The focus of the interventions include: minimizing the negative effects of psychiatric and substance abuse symptoms that interfere with the recipient's daily living; improving and sustaining developmentally appropriate functioning in specified domains; financial management and personal development; developing strategies and supportive interventions for avoiding out-of-home placements; supporting ongoing treatment assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's disability and coordinating rehabilitation services in the Person Centered Plan.

Documentation Requirements
Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Entrance Process
Medicaid covers up to eight unmanaged Qualified Professional hours for the purpose of collecting information to develop and initiate the Person Centered Plan (PCP). Relevant diagnostic information must be obtained to complete the PCP. This requirement may be fulfilled through the Diagnostic/Assessment, intake or recent diagnostic information. This information must reflect medical necessity to correct or ameliorate a defect, physical or mental illness or a condition [health problem] diagnosed by the recipient's physician, therapist or other licensed practitioner to be reviewed under EPSDT criteria. No additional Community Support services can be requested without a complete PCP with signatures and an ITR.

The Qualified Professional may link the recipient to an alternate service within the 8-hour timeframe. This must be documented in the PCP and ITR submitted to the statewide vendor.

Utilization Management
Authorization by the statewide vendor is required after eight unmanaged Qualified Professional hours. The statewide vendor will evaluate the request to determine if medical necessity supports more or less intensive services. ~~The amount, duration, and frequency of the services must be included in an individual's Person Centered Plan, and authorized prior to or on the day services are to be provided. Initial authorization for services may not exceed thirty (30) days. Reauthorization will occur a minimum of (90) days thereafter by the statewide vendor and is to be documented in the Person Centered Plan and service record.~~

If it is a Medicaid covered service, utilization management will be done by the statewide vendor. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Note: Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

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Medically necessary service is authorized in the most economic mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist of other licensed practitioner.

~~A maximum of thirty-two (32) units of Community Support services can be provided in a 24-hour period unless specific authorization for exceeding this limit is approved. No more than112 units per week of Community Support services can be provided to an individual unless specific authorization by the LME/state vender to exceed this limit is approved.~~

If the needed medical information is not yet completed when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information should be included. Interim prior authorizations with variable timelines for resubmittion will occur to assure the delivery of needed services.

Medicaid covers up to 780 units for a 90-day period based the medical necessity documented in the PCP and supporting documentation. If the initial benefit of 780 units is expended before the end of the 90-day period, an updated PCP and a new ITR must be submitted to the statewide vendor to request alternate services. Additional units may be authorized on a time-limited basis to allow time for the Qualified Professional to coordinate these alternate services.

If continued Community Support services are needed at the end of the 90-day authorization period, an updated PCP and a new ITR reflecting the appropriate level of care and service must be submitted to the statewide vendor. This should occur no later than 30 days prior to the expiration of the initial authorization.

Note: Community Support services are not intended to be a long-term service. Continued requests beyond the first six months require significant justification.

Service Exclusions/Limitations

An individual can receive Community Support services from only one Community Support provider organization at a time.

~~Community Support services can not be billed for individuals who are receiving Intensive In-Home service, Multisystemic Therapy, SAIOP, Day Treatment, Level II-IV Child Residential or Substance Abuse Residential services except as referenced below~~

~~**Service Limitation:** Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving one of the services listed above for the purpose of facilitating transition to the service , admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS Professional and discharge planning.~~

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For the purpose of facilitating an admission to a service; a transition to or from a service; or to provide coordination during the provision of a service, Medicaid covers up to 8 units of Community Support services per calendar month for individuals who are authorized to receive one of the following services during the same authorization period:

- Child and Adolescent Day Treatment
- Intensive In-home Services
- Levels II through IV Child Residential Treatment
- Partial Hospitalization
- Residential Treatment Services
- Substance Abuse Intensive Outpatient Treatment
- Substance Abuse Non-medical Residential Treatment

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.